



## General

### Guideline Title

Ipilimumab for previously untreated advanced (unresectable or metastatic) melanoma.

### Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Ipilimumab for previously untreated advanced (unresectable or metastatic) melanoma. London (UK): National Institute for Health and Care Excellence (NICE); 2014 Jul. 52 p. (Technology appraisal guidance; no. 319).

### Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

## Recommendations

### Major Recommendations

Ipilimumab is recommended, within its marketing authorisation, as an option for treating adults with previously untreated advanced (unresectable or metastatic) melanoma, only if the manufacturer provides ipilimumab with the discount agreed in the patient access scheme.

### Clinical Algorithm(s)

None provided

## Scope

### Disease/Condition(s)

Advanced melanoma (unresectable or metastatic)

### Guideline Category

Assessment of Therapeutic Effectiveness

Treatment

## Clinical Specialty

Dermatology

Internal Medicine

Oncology

## Intended Users

Advanced Practice Nurses

Physician Assistants

Physicians

## Guideline Objective(s)

To evaluate the clinical effectiveness and cost-effectiveness of ipilimumab for previously untreated advanced (unresectable or metastatic) melanoma

## Target Population

Adult patients with previously untreated advanced (unresectable or metastatic) melanoma

## Interventions and Practices Considered

Ipilimumab

## Major Outcomes Considered

- Clinical effectiveness
  - Overall survival
  - Progression-free survival
  - Objective response rate
  - Disease control rate
  - Time to response
  - Health-related quality of life
- Cost-effectiveness

## Methodology

### Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

## Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Care Excellence (NICE) commissioned an independent academic centre to perform an assessment of the manufacturer's submission on the technology considered in this appraisal and prepare an Evidence Review Group (ERG) report. The ERG report for this appraisal was prepared by the Centre for Reviews and Dissemination (CRD), Centre for Health Economics (CHE), Technology Assessment Group, University of York (see the "Availability of Companion Documents" field).

### Clinical Effectiveness

#### Critique of Method(s) of Reviews

##### *Search Strategy*

The manufacturer's submission (MS) described the systematic review search strategies used to identify relevant clinical effectiveness studies on the use of ipilimumab and comparator therapies for the treatment of adult patients with previously untreated advanced malignant melanoma. The search strategies were described in the main body of the submission, and full details were provided in the Appendices.

The electronic databases MEDLINE, MEDLINE In-process, EMBASE, the Cochrane Library (including the Cochrane Database of Systematic Reviews, the Cochrane Central Register of Controlled Trials, the Health Technology Assessment Database and the Database of Abstracts of Reviews of Effects [DARE]), CINAHL and ClinicalTrials.gov were searched in May 2013. In addition, the 2009 to 2012 conference proceedings of the American Society of Clinical Oncology (ASCO), the European Society for Medical Oncology (ESMO) and the Society for Melanoma Research (SMR) were searched on 9th May 2013. The manufacturer attempted to search the conference proceedings of the European Association of Dermato-Oncologists (EADO) and Perspectives in Melanoma (PiM), however the abstracts could not be accessed as abstracts are only made available to meeting delegates, so could not be searched. The reference lists of previous systematic reviews and clinical guidelines identified were hand searched to identify any additional relevant studies, and unpublished data from Bristol-Myers Squibb were reviewed for relevance to the research question. Search strategies used for each database were documented in Appendix 2, Section 10.2.4 of the MS.

Searches were limited to studies published between 1970 and May 2013, with the justification that the earliest melanoma trial was published in 1972. In view of the therapies eligible for inclusion in the review, this was appropriate. The searches were not limited by language.

In Appendix 6 (Section 10.6), under 'Search strategy for Section 6.8 (Non-RCT evidence)', the MS states 'Not applicable' for each of the subsections; however, non-randomised controlled trial (non-RCT) evidence was included in the review. Therefore, it is unclear in the MS how these studies were identified. The ERG asked the manufacturer to clarify how non-RCT evidence was identified; the manufacturer responded that non-RCT evidence was not searched for systematically because direct RCT evidence was identified for comparator therapies, therefore, non-RCT evidence was only required for ipilimumab 3 mg/kg monotherapy. The manufacturer stated that the non-RCT evidence is derived from ongoing trials or pooled data analysis that are not currently available in full, in the public domain.

Generally, the search strategies were well reported in the MS. The exact strategies used along with the databases searched, the database service provider, dates of searches and date span of the searches are all clearly reported. Searches for both published and unpublished literature were carried out and all of the NICE specified databases were searched.

The textword and subject headings used in the search strategies for ipilimumab and the comparator drugs were appropriate. Various synonyms and spelling variations for melanoma or skin cancer have been included in the strategy. However the terms neoplas\$ and tumor\$ have not been included. Boolean operators, truncation and field searches have been used appropriately.

The search strategies were limited to randomised controlled trials (RCTs) or systematic reviews using study design filters developed by the Scottish Intercollegiate Guidelines Network (SIGN). The SIGN filters have been developed in-house and have not been independently validated. Other validated search filters with high sensitivity are freely available and could have been used. A further issue with restricting the clinical effectiveness searches to RCTs or systematic reviews is that adverse events data from other study types may not have been identified.

Unpublished literature was sought from Clinicaltrials.gov using an appropriate search strategy. In addition, several conference proceedings were searched; however details of how they were searched were not reported.

Although minor issues have been raised with the search strategies for clinical effectiveness, it is unlikely that any relevant RCTs have been missed. Non-RCT evidence was not searched for systematically; however, the manufacturer stated that non-RCT evidence for ipilimumab 3 mg/kg monotherapy is derived from ongoing trials or pooled data analysis that are not currently available in full, in the public domain.

### *Inclusion Criteria*

Studies had to have at least an abstract reported in English to be screened for inclusion in the review. No details of the study selection process were described in the MS; therefore, it is unclear whether appropriate methods were used to reduce the potential for reviewer bias and error.

The inclusion criteria relating to the population of interest appear to have been appropriate and in line with both the decision problem and the marketing authorisation of ipilimumab. The inclusion criteria relating to outcomes of interest appear to have been appropriate, and included all those specified in the scope.

As discussed in Section 3.3 in the ERG report, it is unclear why dabrafenib was added to the inclusion criteria relating to interventions of interest, as this was not presented in Table 4 of the MS, which presented the decision problem addressed in the submission. The manufacturer stated that it was included as a clinical comparator, as it is licensed for monotherapy for the treatment of adult patients with unresectable or metastatic melanoma with a BRAF V600 mutation, and is currently scheduled for a NICE technology appraisal. However, it does not meet the reference case for comparators, defined as "therapies routinely used in the National Health Service (NHS), including technologies regarded as current best practice".

Prospective non-RCTs and observational studies were listed under 'exclusion criteria' for the review of the clinical effectiveness data; however, two ongoing retrospective observational studies and a pooled analysis of a subgroup of patients included in four RCTs were included in the MS, due to the lack of RCT evidence directly investigating ipilimumab 3 mg/kg monotherapy in untreated patients. Non-RCT evidence was not searched for systematically (see Section 4.1.1 in the ERG report [see the "Availability of Companion Documents" field]).

A flow chart of the study selection process was presented in the MS (see Figure 5 in the MS), which stated that six original RCTs were included in a quantitative synthesis. An additional record of an ongoing trial was included in the qualitative synthesis, along with nine kin publications, related to the six included RCTs.

The ERG searched MEDLINE, EMBASE, the Cochrane Central Register of Controlled Trials, ClinicalTrials.gov, the EU Clinical Trials Register and the WHO Trials Registry and did not identify any additional RCTs that should have been included in the review.

### Cost-effectiveness

#### ERG Comment on Manufacturer's Review of Cost-effectiveness Evidence

#### *Searches*

The manufacturer undertook a systematic literature review to identify cost-effectiveness studies relevant to this appraisal of ipilimumab for the treatment of previously untreated advanced (unresectable or metastatic) malignant melanoma. The search strategies were described in the main body of the submission, and full details were provided in the Appendices.

The electronic databases MEDLINE, MEDLINE In-process, EMBASE, EconLIT, the Cochrane Library (including NHS Economic Evaluation Database [NHS EED], the Cochrane Database of Systematic Reviews, the Health Technology Assessment Database and the Database of Abstracts of Reviews of Effects [DARE]) and Cumulative Index to Nursing and Allied Health Literature (CINAHL) were searched. In addition to the formal electronic searches, reference lists of included cost-effectiveness and quality-of-life studies were hand searched for additional relevant studies. Searches for each database were reported in Appendix 10, Section 10.10 of the MS.

The searches were performed on the 9th May 2013 and covered the period 1946-May 2013 for MEDLINE and MEDLINE In-Process, 1974-May 2013 for EMBASE, 1996-May 2013 for Cochrane Database of Systematic Reviews, 1995-May 2013 for HTA database, DARE and NHS EED, 1981-May 2013 for CINAHL and 1961-April 2013 for EconLit. Several of the databases had a date limit of 1970 applied to the results of the searches: MEDLINE and MEDLINE In-process, Cochrane Database of Systematic Reviews, HTA database, DARE and NHS EED. No language restrictions were applied.

Generally, the search strategies were well reported in the MS. The exact strategies used along with the databases searched, the database service provider, dates of searches and date span of the searches were all clearly reported. All of the NICE specified databases were searched.

As with the clinical evidence searches, the textword and subject headings used in the search strategies for ipilimumab and the comparator drugs were appropriate. Various synonyms and spelling variations for melanoma or skin cancer have been included in the strategy. However neoplas\$ and tumor\$ have not been included. Boolean operators, truncation and field searches have been used appropriately. A precise economics filter

developed by SIGN was used to limit retrieval to economic studies.

#### *Inclusion/Exclusion Criteria Used for Study Selection*

To be considered relevant to the analysis, the identified studies had to be full economic evaluations, i.e., cost-consequence, cost-minimisation, cost-effectiveness, cost-utility and cost-benefit evaluations that compared ipilimumab to one or more of its comparators. The comparators included in the search were DTIC, dabrafenib and vemurafenib. Letters, editorials and reviews of economic evaluations were excluded, although reference lists of the latter were hand-searched. The ERG considers the inclusion/exclusion criterion to be reasonable and would have been expected to identify any relevant studies.

## Number of Source Documents

### Clinical Effectiveness

4 randomised controlled trials were identified and included in the manufacturer's submission.

### Cost-effectiveness

204 studies were initially identified. 197 of the 204 studies were excluded during primary filtering, either for being the wrong study type (n=184), wrong line of treatment (n=6), wrong intervention (n=4) or a duplicate/review (n=3). Of the seven studies remaining for secondary filtering, six were the wrong study type and one was using the wrong intervention. The manufacturer's search did not identify any relevant economic assessments of ipilimumab as a first line treatment. Therefore, the Evidence Review Group (ERG) considered the cost-effectiveness analysis reported in the current submission to be the most relevant source of evidence to inform the decision problem.

## Methods Used to Assess the Quality and Strength of the Evidence

### Expert Consensus

## Rating Scheme for the Strength of the Evidence

### Not applicable

## Methods Used to Analyze the Evidence

### Review of Published Meta-Analyses

### Systematic Review with Evidence Tables

## Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Care Excellence (NICE) commissioned an independent academic centre to perform an assessment of the manufacturer's submission on the technology considered in this appraisal and prepare an Evidence Review Group (ERG) report. The ERG report for this appraisal was prepared by Centre for Reviews and Dissemination (CRD), Centre for Health Economics (CHE), Technology Assessment Group, University of York (see the "Availability of Companion Documents" field).

### Clinical Effectiveness

### Data Extraction

Two reviewers independently extracted data from the included trials into a pre-defined data extraction table designed in Microsoft Access®, reducing the potential for error or bias. In case of disagreement between the two reviewers, a third reviewer would have extracted data with final results attained by consensus, however, this was not necessary.

Adequate data from the four included randomised controlled trials (RCTs) were presented in the manufacturer's submission (MS).

It is unclear how data from the included observational studies were extracted, as no details were provided in the MS for non-RCT evidence (MS Appendix 6, Section 10.6.7).

## Quality Assessment

A table of the quality assessment results for the four included RCTs was presented in the MS (Table 15 in the MS), which included the quality criteria specified by NICE. In addition, further details were presented in Appendix 3 in the MS; although there were some minor inconsistencies between the quality assessment results presented in Table 15 and those presented in Appendix 3, relating to the adequacy of concealment of treatment allocation for the open label trials (which was coded as 'adequate' or 'unclear' in Table 15, but 'not applicable' in Appendix 3).

Quality assessment results were checked by the ERG. However, the ERG was unable to find details of the methods of randomisation for the MDX010-08 and BRIM-3 trials within the study reports. The MS stated that these were undertaken using a centralised randomisation scheme.

The quality of the included non-RCT evidence was presented in Appendix 7 in the MS. The manufacturer acknowledged the potential biases introduced through the use of retrospective observational data and pooled analyses.

## Evidence Synthesis

The manufacturer described the results of the individual trials separately, which was appropriate in view of the differences in study design, participant and intervention characteristics.

A mixed treatment comparison of ipilimumab (10 mg/kg plus DTIC), and the BRAF inhibitors vemurafenib and dabrafenib was presented, using the CA184-024, BRIM-3 and BREAK-3 trials, with DTIC being the common comparator treatment in each of the trials. Indirect pairwise comparisons, determined using the Bucher method, were also presented. The ERG does not consider these analyses to be appropriate because of differences in patients' baseline characteristics between the ipilimumab, vemurafenib and dabrafenib trials, resulting in patients in the vemurafenib and dabrafenib trials having a worse prognosis than patients in the ipilimumab trial (differences in the proportion of patients with elevated serum lactate dehydrogenase levels and M1c disease).

## Cost-effectiveness

### ERG's Summary and Critique of Manufacturer's Submitted Economic Evaluation

The manufacturer's economic submission included a report on the de novo economic evaluation conducted by the manufacturer. The report described the patient population, model structure, technology and comparators (MS, Section 7.2); clinical parameters, modelling techniques employed and assumptions made to model the clinical outcomes (MS, Section 7.3); the assumptions and sources of evidence used to assess quality of life (MS, Section 7.4); the resource use and unit cost assumptions and sources (MS, Section 7.5); the sensitivity analyses undertaken (MS, Section 7.6); and the cost-effectiveness results for the base-case and sensitivity analysis (MS, Section 7.7).

An overall summary of the manufacturer's approach and signposts to the relevant sections in the MS are reported in Table 5.1 in the ERG report (see the "Availability of Companion Documents" field).

## Methods Used to Formulate the Recommendations

### Expert Consensus

## Description of Methods Used to Formulate the Recommendations

### Considerations

Technology appraisal recommendations are based on a review of clinical and economic evidence.

### Technology Appraisal Process

The National Institute for Health and Care Excellence (NICE) invites 'consultee' and 'commentator' organisations to take part in the appraisal process. Consultee organisations include national groups representing patients and carers, the bodies representing health professionals, and the manufacturers of the technology under review. Consultees are invited to submit evidence during the appraisal and to comment on the appraisal documents.

Commentator organisations include manufacturers of the products with which the technology is being compared, the National Health Service

(NHS) Quality Improvement Scotland and research groups working in the area. They can comment on the evidence and other documents but are not asked to submit evidence themselves.

NICE then commissions an independent academic centre to review published evidence on the technology and prepare an 'assessment report'. Consultees and commentators are invited to comment on the report. The assessment report and the comments on it are then drawn together in a document called the evaluation report.

An independent Appraisal Committee then considers the evaluation report. It holds a meeting where it hears direct, spoken evidence from nominated clinical experts, patients and carers. The Committee uses all the evidence to make its first recommendations, in a document called the 'appraisal consultation document' (ACD). NICE sends all the consultees and commentators a copy of this document and posts it on the NICE Web site. Further comments are invited from everyone taking part.

When the Committee meets again it considers any comments submitted on the ACD; then it prepares its final recommendations in a document called the 'final appraisal determination' (FAD). This is submitted to NICE for approval.

Consultees have a chance to appeal against the final recommendations in the FAD. If there are no appeals, the final recommendations become the basis of the guidance that NICE issues.

Who Is on the Appraisal Committee?

NICE technology appraisal recommendations are prepared by an independent committee. This includes health professionals working in the NHS and people who are familiar with the issues affecting patients and carers. Although the Appraisal Committee seeks the views of organisations representing health professionals, patients, carers, manufacturers and government, its advice is independent of any vested interests.

## Rating Scheme for the Strength of the Recommendations

Not applicable

## Cost Analysis

### Summary of Appraisal Committee's Key Conclusions on the Evidence for Cost-effectiveness

#### Availability and Nature of Evidence

The manufacturer's original submission presented a semi-Markov partitioned survival model, using second-line active treatment (from the CA184-024 trial) and third-line best supportive care. For vemurafenib, data from the vemurafenib arm of the BRIM-3 trial were incorporated directly into the model.

In response to the consultation, the manufacturer presented an updated base-case and incremental cost-effectiveness ratios (ICERs) using the 3-state model and adjusted overall survival curves. The manufacturer also carried out 2 modifications to enhance the validity of the sequential model. Firstly, the mortality hazard for third-line treatment was assumed to be the same as for second-line ipilimumab. The second modification involved the use of survival curves from the MDX010-20 trial, taking into account patient baseline characteristics from the CA184-024 trial, rather than the use of hazard ratios to estimate efficacy of second-line ipilimumab.

#### Uncertainties Around and Plausibility of Assumptions and Inputs in the Economic Model

The Committee considered the manufacturer's response to consultation and the updated analyses using the adjusted overall survival curve from the second-line trial MDX010-20 to estimate the clinical effectiveness of 3 mg/kg ipilimumab first-line. The Committee was aware that in the updated base-case analysis, the manufacturer used overall survival and progression-free survival for ipilimumab from the previous appraisal (TA268), and overall survival and progression-free survival for dacarbazine were taken from the CA184-024 trial. The data were then adjusted to take into account differences in the patient baseline characteristics. The Committee noted concerns from the Evidence Review Group (ERG) that the approach used by the manufacturer was inconsistent with the previous appraisal.

Incorporation of Health-related Quality-of-Life Benefits and Utility Values. Have Any Potential Significant and Substantial Health-related Benefits Been Identified That Were Not Included in the Economic Model, and How Have They Been Considered?

European Organisation for Research and Treatment of Cancer questionnaire (EORTC-QLQ-C30) utility data were collected in the CA184-024 trial but there were lower completion rates among surviving patients at certain time points.

The ERG was concerned at the lack of direct EuroQOL 5 dimension (EQ-5D) data.

Are There Specific Groups of People for Whom the Technology Is Particularly Cost Effective?

No. The clinical specialists stated that although it is not possible to identify patients most likely to experience a response with ipilimumab, it was associated with a very durable response in some patients whose condition responds to treatment.

What Are the Key Drivers of Cost-effectiveness?

In the updated model, cost-effectiveness was most affected by shortening the time horizon but generally the results were insensitive to changes. The Committee also noted that the use of a 3-state model, which the ERG preferred to the sequential modelling used in the manufacturer's original submission, and lower estimates of effectiveness for ipilimumab, produced substantially higher ICERs than in the original submission.

Most Likely Cost-effectiveness Estimate (Given as an ICER)

The Committee considered the manufacturer's updated base-case results submitted in response to consultation. The Committee concluded that the most plausible ICER is £47,900 per quality-adjusted life year (QALY) gained for ipilimumab compared with dacarbazine and £28,600 per QALY gained for ipilimumab compared with vemurafenib.

## Method of Guideline Validation

External Peer Review

## Description of Method of Guideline Validation

Consultee organizations from the following groups were invited to comment on the draft scope, Assessment Report and the Appraisal Consultation Document (ACD) and were provided with the opportunity to appeal against the Final Appraisal Determination:

- Manufacturer/sponsors
- Professional/specialist and patient/carer groups
- Commentator organisations (without the right of appeal)

In addition, individuals selected from clinical expert and patient advocate nominations from the professional/specialist and patient/carer groups were also invited to comment on the ACD.

## Evidence Supporting the Recommendations

### Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

The Appraisal Committee considered clinical and cost-effectiveness evidence submitted by the manufacturer of ipilimumab and a review of this submission by the Evidence Review Group (ERG). The main clinical effectiveness evidence came from randomised controlled trials, retrospective observational trials, and a pooled analysis of randomised trials. For cost-effectiveness, the Appraisal Committee considered an economic model submitted by the manufacturer.

## Benefits/Harms of Implementing the Guideline Recommendations

### Potential Benefits

Appropriate use of ipilimumab for previously untreated advanced (unresectable or metastatic) melanoma

## Potential Harms

The summary of product characteristics lists the following very common adverse reactions for ipilimumab: diarrhoea, rash, pruritus, fatigue, nausea, vomiting, decreased appetite and abdominal pain.

For full details of adverse reactions, see the summary of product characteristics.

## Contraindications

### Contraindications

For full details of contraindications, see the summary of product characteristics of ipilimumab.

## Qualifying Statements

### Qualifying Statements

- This guidance represents the views of the National Institute for Health and Care Excellence (NICE) and was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

## Implementation of the Guideline

### Description of Implementation Strategy

- The Department of Health and the manufacturer have agreed that ipilimumab will be available to the National Health Service (NHS) with a patient access scheme which makes ipilimumab available with a discount. The size of the discount is commercial in confidence. It is the responsibility of the manufacturer to communicate details of the discount to the relevant NHS organisations. Any enquiries from NHS organisations about the patient access scheme should be directed to: Bristol-Myers Squibb, telephone number 01244 586250, email [mgukpasadmin@bms.com](mailto:mgukpasadmin@bms.com)
- The National Institute for Health and Care Excellence (NICE) has developed a [costing statement](#)  (see also the "Availability of Companion Documents" field) to estimate the national and local savings and costs associated with implementation to help organisations put this guidance into practice.

## Implementation Tools

Mobile Device Resources

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

# Institute of Medicine (IOM) National Healthcare Quality Report Categories

## IOM Care Need

Living with Illness

## IOM Domain

Effectiveness

Patient-centeredness

## Identifying Information and Availability

### Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Ipilimumab for previously untreated advanced (unresectable or metastatic) melanoma. London (UK): National Institute for Health and Care Excellence (NICE); 2014 Jul. 52 p. (Technology appraisal guidance; no. 319).

### Adaptation

Not applicable: The guideline was not adapted from another source.

### Date Released

2014 Jul

### Guideline Developer(s)

National Institute for Health and Care Excellence (NICE) - National Government Agency [Non-U.S.]

### Source(s) of Funding

National Institute for Health and Care Excellence (NICE)

### Guideline Committee

Appraisal Committee

### Composition of Group That Authored the Guideline

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## Financial Disclosures/Conflicts of Interest

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

## Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

## Guideline Availability

Electronic copies: Available from the [National Institute for Health and Care Excellence \(NICE\) Web site](#) .

## Availability of Companion Documents

The following are available:

- Ipilimumab for previously untreated advanced (unresectable or metastatic) melanoma. Costing statement. London (UK): National Institute for Health and Care Excellence (NICE); 2014 Jul. (Technology appraisal guidance; no. 319). Electronic copies: Available in from the [National Institute for Health and Care Excellence \(NICE\) Web site](#) .
- Wade R, Giannopoulou C, Sideris E, Moe-Byrne T, Harden M, McKenna C, Eastwood A. Ipilimumab for previously untreated unresectable malignant melanoma: a single technology appraisal. York (UK): CRD and CHE Technology Assessment Group; 2013 Dec. 131 p. Electronic copies: Available from the [NICE Web site](#) .

## Patient Resources

The following is available:

- Ipilimumab for previously untreated advanced (unresectable or metastatic) melanoma. Information for the public. London (UK): National Institute for Health and Care Excellence (NICE); 2014 Jul. (Technology appraisal guidance; no. 319). Electronic copies: Available from the [National Institute for Health and Care Excellence \(NICE\) Web site](#) . Also available for download as a Kindle or EPUB ebook from the [NICE Web site](#) .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better

understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## NGC Status

This NGC summary was completed by ECRI Institute on September 10, 2014.

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